

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4206

County

Talbot

78  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 290

Village or City

Easton Md.

St.; Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

2 FULL NAME

Sarah C. Cooke

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

April 13, 1867  
(Month) (Day) (Year)

7 AGE

47 yrs. 0 mos. 17 ds. OR LESS than  
1 day.....hrs.  
OR.....min.?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

Housewife

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country)

Talbot Co

PARENTS

10 NAME OF FATHER

James A. Redman

11 BIRTHPLACE OF FATHER  
(State or country)

Talbot Co

12 MAIDEN NAME OF MOTHER

Mary J. Callahan

13 BIRTHPLACE OF MOTHER  
(State or country)

Talbot Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Aphronia A. Golt

(Address)

Brenton Md.

15

Filed

5/2, 1914 B. Fairbank

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 30, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Apr 27th 1914 to Apr 27th 1914

that I last saw h. or alive on Apr 27th 1914

and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

Contributory  
Secondary

(Duration) 22 yrs. mos. ds.

(Signed)

P. L. Taven

M. D.

May 2nd 1914 (Address) Brenton Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Easton Md.

5/2, 1914

20 UNDERTAKER

ADDRESS

James A. Spence Easton Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

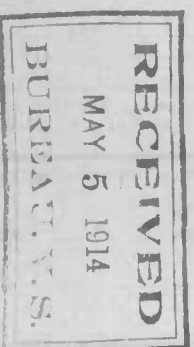
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis", etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recoiler wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

*Talbot*

4207

31

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *290*

Village or City

*Easton Md.*

St.; Ward)

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

*Daniel D. Dobson*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*Caucasian*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*Single*

6 DATE OF BIRTH

*Oct 22, 1881*  
(Month) (Day) (Year)

7 AGE

*32 yrs. 3 mos. 20 ds.*  
If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

*At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

*"*

9 BIRTHPLACE

(State or country)

*Talbot Co*

10 NAME OF FATHER

*Base Dobson*

11 BIRTHPLACE OF FATHER

(State or country)

*Talbot Co*

12 MAIDEN NAME OF MOTHER

*Emaline Bailey*

13 BIRTHPLACE OF MOTHER

(State or country)

*Baltimore*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Chas H. Dobson*

(Address)

*Easton Md*

15

Filed

*4/14, 1914**B. Fairbank*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*April 11, 1914*  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I last saw him alive on 191

and that death occurred on the date stated above, at *8:40 P.* m.

The CAUSE OF DEATH\* was as follows:

*Tubercular Peritonitis*(Duration) yrs. *2* mos. ds.Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

*J. H. Adams*, M. D.191 (Address) *Coastal Rd.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Hammondston**4/14, 1914*

20 UNDERTAKER

ADDRESS

*James A. Spauld**Easton Md*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

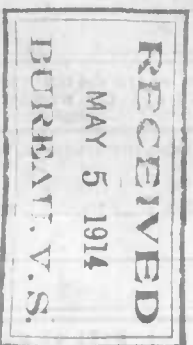
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4208

County Talbot

(92) STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 290Village or City Easton Md. (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

2 FULL NAME Addie M. Fleckenstein

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
ORDIVORCED  
(Write the word)Married

6 DATE OF BIRTH

March 28, 1880  
(Month) (Day) (Year)

7 AGE

64 yrs. 1 mos. 10 ds. OR LESS than  
1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of workAt Home(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

Lancaster Co Pa

PARENTS

10 NAME OF  
FATHERJohn Kauffman11 BIRTHPLACE  
OF FATHER  
(State or country)Lancaster Co, Pa.12 MAIDEN NAME  
OF MOTHERSusan Myers13 BIRTHPLACE  
OF MOTHER  
(State or country)Lancaster Co Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. M. Fleckenstein

(Address)

Easton Md.

15

Filed 4/20, 1914J. B. Fairbank  
LOCAL REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 18, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

April 11, 1914, to April 18, 1914,  
that I last saw her alive on April 18, 1914and that death occurred on the date stated above, at 3:10 a.m.,

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 7 ds.Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

W. M. Palmer, M. D.

, 191\_\_\_\_\_ (Address)

Easton Md\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Easton Md.4/20, 1914

20 UNDERTAKER

ADDRESS

James A. Spence Easton Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

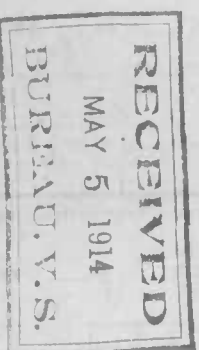
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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4209  
County Talbot Co

28  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 293

Village or City 2 near Anne (No.       , St.        Ward       )

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Catharine L. Thompson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Feb 4, 1892  
(Month) (Day) (Year)

7 AGE 22 yrs. 1 mos. 27 ds. If LESS than 1 day,        hrs. OR        min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)       

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER William Kline

11 BIRTHPLACE OF FATHER (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Ella L. Pyle

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W. Birdley  
(Address) Hillsboro Md

15 Filed May 1, 1914. J. L. Gardner REGISTRAR  
      

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 14, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1914, to April 14, 1914.

that I last saw her alive on March 28, 1914.

and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis lungs throat

(Duration) 6 yrs. 6 mos.        ds.

Contributory (Secondary)       

(Signed) Howard R. Hopkins, M. D.

Apr. 1 -, 1914, (Address) Hillsboro.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.

Where was disease contracted, If not at place of death?       

Former or usual residence       

19 PLACE OF BURIAL OR REMOVAL Hillsboro DATE OF BURIAL April 4, 1914

20 UNDERTAKER J. P. Bitchett ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAY 2 1914  
BUREAU, U. S.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4210

County TalbotVillage or City Near CordovaSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 293

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary C. George

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Dec 10, 1844  
(Month) (Day) (Year)

7 AGE 69 yrs 3 mos 26 ds If LESS than 1 day, .... hrs. OR .... min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER George Caldwell

11 BIRTHPLACE OF FATHER (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary C. Riley

13 BIRTHPLACE OF MOTHER (State or country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John F. George(Address) Cordova

15 Filed May 1, 1914 J. L. Gardner REGISTRAR  
Local

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 5, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar. 18<sup>th</sup>, 1914 to Apr 4<sup>th</sup>, 1914

that I last saw him alive on Apr 4, 1914

and that death occurred on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH\* was as follows:

Nephritis, with Cardiac Hypertrophy

(Duration) 3 yrs. 0 mos. 0 ds.

Contributory was paralyzed on  
Secondary left side (Duration) 10 yrs. 0 mos. 0 ds.

(Signed) C. W. Mott, M. D.  
Apr 5, 1914 (Address) Cordova, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Easton Md DATE OF BURIAL 4/7, 1914

20 UNDERTAKER Spence & Mullikin ADDRESS Easton, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

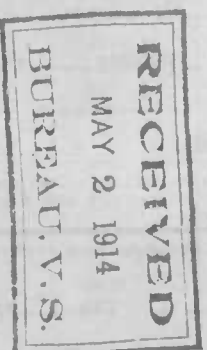
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH **4211**  
County Salt St.

**STATE OF MARYLAND  
CERTIFICATE OF DEATH**

Registration Dist. No. 292

Village or City Offord (No. Tilghman St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Lachel Gibson

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow  
(Write the word)

6 DATE OF BIRTH Unknown, 1880  
(Month) (Day) (Year)

7 AGE 84 yrs. 0 mos. 0 ds. OR 1 day, 0 hrs. 0 min. ?  
If LESS than 1 day, .... hrs. .... min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Domestic  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Leambridge Md.

10 NAME OF FATHER Daniel Raro

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(Address) \_\_\_\_\_

16 Filed April 18, 1914 W. S. Nichols  
Deputy Local REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH April 17th, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April, 1912 to April 16th, 1914

that I last saw her alive on April 16th, 1914

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH\* was as follows:

Paralysis

(Duration) 2 yrs. 0 mos. 0 ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. M. C. C. C., M. D.

, 191\_\_\_\_ (Address) Offord Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Trappe

DATE OF BURIAL April 19, 1914

20 UNDERTAKER Spence & Mullikin

ADDRESS Easton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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RECEIVED

MAY 5 1914

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4212

County TalbotVillage or City Near Canton

(No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward)

Registered No. 290

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Gross

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH April 21, 1914  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md. Talbot Co.

## PARENTS

10 NAME OF FATHER Isaac Gross

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Lilly Bolden

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. T. Hammond  
(Address) Canton Md

15 Filed April 21, 1914 J. B. Fairbank  
Local REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr. 21, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 21, 1914, to Apr 21, 1914, that I last saw him alive on \_\_\_\_\_, 1914.

and that death occurred on the date stated above, at 4 A. m.  
The CAUSE OF DEATH\* was as follows:

Premature delivery  
still born  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. T. Hammond, M. D.  
Apr 21, 1914 (Address) Canton Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Lowndes Estate DATE OF BURIAL Apr 21, 1914

20 UNDERTAKER Parent ADDRESS Canton, Md. R. 7-20  
Isaac Gross



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

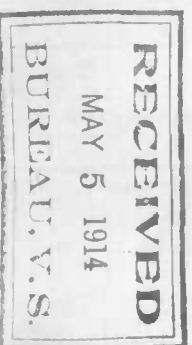
[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of ..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4213

County

Tallot

Village or City

Bozman

(No.

St.

Ward)

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Annie R. Harrison

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Dec

(Month)

(Day)

1851 (Year)

7 AGE

62 yrs. 4 mos. ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Tallot

PARENTS

10 NAME OF FATHER

Joshua Harrison

11 BIRTHPLACE OF FATHER

(State or country)

Tallot Co.

12 MAIDEN NAME OF MOTHER

Hester P. Massey

13 BIRTHPLACE OF MOTHER

(State or country)

Tallot Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joshua R. Harrison

(Address)

Bozman

15

Filed

191

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

(66)

Registration Dist. No.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Apr.

23

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That attended deceased from

Apr 23

1914

to

Apr 23

1914

that I last saw him alive on

and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

Paralysis

Contributory  
Secondary

(Duration)

6

hrs.

ds.

(Duration)

yrs.

mos.

ds.

(Signed)

W. B. Smith

M. D.

Apr 24

1914

(Address)

St Michael

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bozman Md

April 25, 1914

20 UNDERTAKER

ADDRESS

E P Sparks

St Michael

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

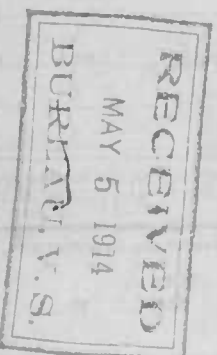
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recoiler wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4214

County

Talbot

Village or City

Dropper

(No. ,

St. Ward)

Registration Dist. No. 293

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Arthur Eugene Hazleton

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Negro

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Sept 6, 1913  
(Month) (Day) (Year)

7 AGE

7 yrs. 7 mos. 50 ds. OR 1 day, 1 hrs. 1 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE (State or country)

Talbot Co. Md.

## PARENTS

10 NAME OF FATHER

Clarence Hamilton

11 BIRTHPLACE OF FATHER (State or country)

Talbot Co. Md.

12 MAIDEN NAME OF MOTHER

Euphonia Hazleton

13 BIRTHPLACE OF MOTHER (State or country)

Baltimore, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Euphonia Hazleton

(Address)

Dropper, Md.

15

Filed

April 11, 1914

J. S. Brown, Jr.

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 11, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I last saw him alive on 191,

and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(Duration) yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. S. Brown, Jr.

M. D.

April 11, 1914 (Address)

Dropper, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Dropper, Md.

DATE OF BURIAL

Apr 13, 1914

20 UNDERTAKER

M. E. Brown

ADDRESS

Dropper, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

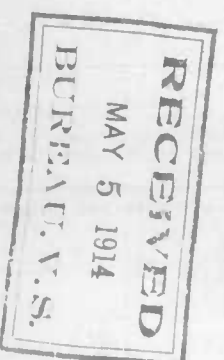
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma, Sarcoma*, etc., of \_\_\_\_\_ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

4215

County

Jacob

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

290

Village or City

Easton Md

(No.)

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Laura P. Holleyday

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
ORDIVORCED  
(Write the word)

Widowed

6 DATE OF BIRTH

March 2nd, 1829

(Month)

(Day)

(Year)

7 AGE

85 yrs. 1 mos. 13 ds.

It LESS than  
1 day, .... hrs.  
OR .... min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

"

9 BIRTHPLACE

(State or country)

Loudoun Co. Va.

PARENTS

10 NAME OF FATHER

Humphrey B. Powell

11 BIRTHPLACE OF FATHER

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Ann Boyd

13 BIRTHPLACE OF MOTHER

(State or country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. B. Holleyday

(Address)

New Harrow Conn.

15

Filed

4/19

1914

J. B. Fairbank

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 17, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

May 1, 1914 to April 17, 1914.

that I last saw her alive on April 17, 1914.

and that death occurred on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH\* was as follows:

Arterial insufficiency

(Duration) yrs. 6 mos. 0 ds.

Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed)

April 18, 1914 (Address) Easton

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Easton Md

4/19, 1914

20 UNDERTAKER

ADDRESS

James A. Spencer Easton Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAY 5 1914  
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		4216		STATE OF MARYLAND	
County <u>Talbot</u>				CERTIFICATE OF DEATH	
Village or City <u>Sherwood</u> (No. _____)		St; _____ Ward _____		Registered No. <u>294</u>	
2 FULL NAME <u>Maria Louisa Landin</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widow</u> (Write the word)			
6 DATE OF BIRTH <u>September 30, 1827</u> (Month) (Day) (Year)					
7 AGE <u>86</u> yrs. <u>6</u> mos. <u>21</u> ds. <u>OR</u> LESS than 1 day, ____ hrs. ____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>					
9 BIRTHPLACE (State or country) <u>Sherwood, Md.</u>					
PARENTS	10 NAME OF FATHER <u>William Lowe</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Sherwood, Md.</u>				
	12 MAIDEN NAME OF MOTHER <u>Keturah Landin</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Talbot Co. Md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Robert Lowe</u> (Address) <u>Sherwood, Md.</u>					
15 <u>April 21, 1914</u> Filed <u>Wm S. Lowrey</u> Local REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>April 19, 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>August 10, 1913</u> to <u>April 19, 1914</u> , that I last saw her alive on <u>April 19, 1914</u> , and that death occurred on the date stated above, at <u>3 P. m.</u> The CAUSE OF DEATH* was as follows:					
<u>Arterio Sclerosis</u> (Duration) <u>8</u> yrs. ____ mos. ____ ds. Contributory <u>Cerebral thrombosis</u> (Secondary) (Duration) ____ yrs. <u>4</u> mos. ____ ds. (Signed) <u>Louis H. Heth</u> , M. D. <u>April 20, 1914</u> (Address) <u>W. Sherwood, Md.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2), whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Talbot County</u>				DATE OF BURIAL <u>April 21, 1914</u>	
20 UNDERTAKER <u>O P Sparks</u>				ADDRESS <u>St. Michaels</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

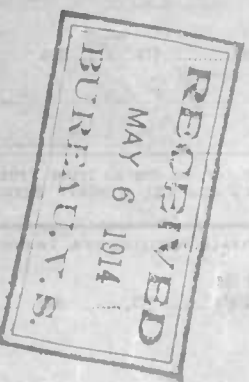
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by runaway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4217

County

Talbot

 115  
 STATE OF MARYLAND  
 CERTIFICATE OF DEATH

, Registration Dist. No. 290

Village or City

Easton Md. Emergency Hospital

Ward)

 [If death occurred in  
 a hospital or institution,  
 give its NAME instead  
 of street and number.]

2 FULL NAME

George Lane

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE,  
MARRIED,  
WIDOWED,  
ORDIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

 Jan 1, 1908  
 (Month) (Day) (Year)

7 AGE

6 yrs. 3 mos. 27 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Talbot Co

10 NAME OF FATHER

Charles Lane

11 BIRTHPLACE OF FATHER (State or country)

Talbot Co

12 MAIDEN NAME OF MOTHER

Fannie Blackwell

13 BIRTHPLACE OF MOTHER (State or country)

Talbot Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Lane

(Address)

Easton Md

15

Filed

April 29, 1914

J. B. Fairbank

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

 April 27, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 20th, 1914 to April 27, 1914

that I last saw him alive on April 27, 1914

and that death occurred on the date stated above, at 12 noon

The CAUSE OF DEATH\* was as follows:

Acute Obstructive Jaundice

(Duration) yrs. mos. 10 ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

W. H. Salmon, M. D.

191 (Address)

Easton Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Copperville

DATE OF BURIAL

4/29, 1914

20 UNDERTAKER

ADDRESS

James A. Spence Easton Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 5 1914  
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4218  
County Balbot

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 294

Village or City McDaniel (No. ...., St.; .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Frances Lowe

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, ☒ MARRIED, ☐ WIDOWED, ☐ OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH October 12, 1886  
(Month) (Day) (Year)

7 AGE 57 yrs. 6 mos. 20 ds. It LESS than 1 day, .... hrs. OR .... min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work farmer's wife  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balbot

10 NAME OF FATHER Francis A. Wrightson

11 BIRTHPLACE OF FATHER (State or country) Balbot

12 MAIDEN NAME OF MOTHER Ellen Jane Graham

13 BIRTHPLACE OF MOTHER (State or country) Balbot

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Lowe  
(Address) McDaniel, Md.

15 Filed April 22, 1914  
Wm. S. Lowe Deputy REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 20, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from August 26, 1910 to April 20, 1914, that I last saw her alive on April 19, 1914

and that death occurred on the date stated above, at 10.30 a.m.  
The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis  
(Duration) 3 yrs. .... mos. .... ds.  
Contributory severe atherosclerosis  
(Secondary) progressive for about  
(Duration) 6 yrs. .... mos. .... ds.

(Signed) Lois H. Smith, M. D.  
April 21, 1914 (Address) McDaniel, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Barton Md DATE OF BURIAL April 22, 1914

20 UNDERTAKER C. P. Sparks ADDRESS St Michaels

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

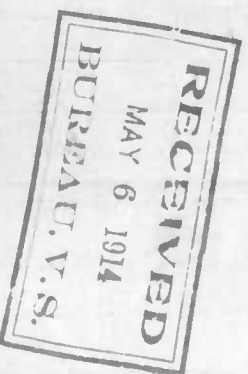
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative faithfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

4219

County

Talbot

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 290

Village or City

Easton Md

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Walter Manskey

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Unknown

(Month) (Day) (Year)

7 AGE

3 1/2 yrs.

— mos. — ds.

if LESS than  
1 day, — hrs.  
OR, — min. ?

8 OCCUPATION

(s) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Teamster

9 BIRTHPLACE

(State or country)

Talbot Co

PARENTS

10 NAME OF FATHER

James Lease James

11 BIRTHPLACE OF FATHER

(State or country)

Talbot Co

12 MAIDEN NAME OF MOTHER

Fannie Manskey

13 BIRTHPLACE OF MOTHER

(State or country)

Talbot Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fannie Manskey

(Address)

Easton Md

15

Filed

4/14

1914

J. B. Fairbank  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 12

1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

March 1st 1914 to March 1st 1914

that I last saw him alive on March 1st 1914

and that death occurred on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH\* was as follows: Came to see me with bad cold, but from history obtained later it must have been Tuberculosis.

(Duration) yrs. 1 mos. ds.

Contributory

General atherosclerosis

Secondary

to Tuberculosis (Duration) yrs. 1/2 mos. ds.

(Signed)

P. L. Travers

M. D.

Apr 14 1914 (Address) Easton Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore 4/14 1914

20 UNDERTAKER

ADDRESS

James A. Spence

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ivanition" "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAY 5 1914

BUREAU, V. S.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4220  
County Talbot  
Village or City Easton (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 290

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Eli Massey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed  
(Write the word)

6 DATE OF BIRTH unknown, 1844  
(Month) (Day) (Year)

7 AGE 70 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country) Delaware

PARENTS  
10 NAME OF FATHER Don't know  
11 BIRTHPLACE OF FATHER (State or country) Don't know  
12 MAIDEN NAME OF MOTHER Don't know  
13 BIRTHPLACE OF MOTHER (State or country) Don't know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm P L Orlin

(Address) Easton Md

15 Filed April 15 1914 J P Fairbank  
Loose REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 15<sup>th</sup>, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1914, to April 15, 1914, that I last saw him alive on April 15, 1914

and that death occurred on the date stated above, at 10:00 a.m., The CAUSE OF DEATH\* was as follows:

Apoplexy  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Wm P L Orlin, M. D.  
, 1914 (Address) Easton Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Easton Md DATE OF BURIAL 4/17, 1914

20 UNDERTAKER Frankton Omaw & Son ADDRESS Easton Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. B. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAY 5 1914  
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Balto</u>		4221		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Trappe</u>		(No. _____)		St.; _____ Ward) _____	
2 FULL NAME <u>Emmett G. Mullikin</u>		Registered No. <u>290</u>			
[If death occurred in a hospital or institution, give its NAME instead of street and number.]					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>March 10</u> , 18 <u>67</u> (Month) (Day) (Year)					
7 AGE <u>47</u> yrs. <u>1</u> mos. <u>9</u> ds.		If LESS than 1 day, _____ hrs. OR _____ min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		<u>Salesman</u>			
9 BIRTHPLACE (State or country)		<u>Maryland</u>			
PARENTS	10 NAME OF FATHER	<u>George W. Mullikin</u>			
	11 BIRTHPLACE OF FATHER (State or country)	<u>Maryland</u>			
	12 MAIDEN NAME OF MOTHER	<u>Emily J. Helsby</u>			
	13 BIRTHPLACE OF MOTHER (State or country)	<u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>G. F. Mullikin</u> (Address) <u>Trappe</u> (P.W.S.S.)					
15 FILED <u>April 22</u> , 191 <u>4</u> <u>B Fairbank</u> Local REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>April 19</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>March</u> , 191 <u>4</u> , to <u>April 19</u> , 191 <u>4</u> , that I last saw him alive on <u>April 19</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>9.45 P.</u> m.					
The CAUSE OF DEATH* was as follows: <u>Pulmonary tuberculosis with laryngeal involvement</u> (Duration) <u>2</u> yrs. <u>8</u> mos. _____ ds.					
Contributory (Secondary) <u>Exhaustion</u> (Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>William S. Seymour</u> , M. D. <u>Apr 20</u> , 191 <u>4</u> (Address) <u>Trappe Md</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Easton Md</u>				DATE OF BURIAL <u>4/22</u> , 191 <u>4</u>	
20 UNDERTAKER <u>John A. Spence</u>				ADDRESS <u>Easton Md</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 5 1914  
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Talbot</u>		4222		(40)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Oxford</u> (No. <u>1</u> )		St.; Ward				Registration Dist. No. <u>292</u>	
2 FULL NAME <u>Aunie M Newman</u>							[If death occurred to a hospital or institution, give its NAME instead of street and number.]
PERSONAL AND STATISTICAL PARTICULARS							MEDICAL CERTIFICATE OF DEATH
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Blk</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>		16 DATE OF DEATH <u>April 10</u> , 191 <u>4</u> (Month) (Day) (Year)			
6 DATE OF BIRTH <u>May 13</u> , 18 <u>59</u> (Month) (Day) (Year)		7 AGE <u>54</u> yrs. <u>10</u> mos. <u>30</u> ds. If LESS than 1 day.....hrs. OR.....min. ?		17 I HEREBY CERTIFY, That I attended deceased from <u>April 9</u> , 191 <u>4</u> , to <u>April 10</u> , 191 <u>4</u> , that I last saw her alive on <u>April 9</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>6.10</u> a.m. The CAUSE OF DEATH* was as follows: <u>Carcinoma of Liver</u> (Duration) <u>1</u> yrs. <u>0</u> mos. <u>0</u> ds.			
8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)		<u>Housework</u>		Contributory <u>Aschima</u> Secondary			
9 BIRTHPLACE (State or country)		<u>Talbot County</u>		(Signed) <u>Balth To Days M. D.</u> <u>April 10, 1914</u> (Address) <u>Oxford Md.</u> (Duration) <u>0</u> yrs. <u>30</u> mos. <u>30</u> ds.			
PARENTS	10 NAME OF FATHER	<u>Garrison Gibson</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
	11 BIRTHPLACE OF FATHER (State or country)	<u>Talbot Co</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. to the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____			
	12 MAIDEN NAME OF MOTHER	<u>Rebecca Gibson</u>		19 PLACE OF BURIAL OR REMOVAL <u>Trappe Md.</u>			
	13 BIRTHPLACE OF MOTHER (State or country)	<u>Talbot Co</u>		DATE OF BURIAL <u>April 12, 1914</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs E Newman</u> (Address) <u>Oxford Md</u>							
15 Filed <u>Apr 11</u> , 191 <u>4</u>		REGISTRAR <u>H. H. Mullikin</u>					
ADDRESS <u>Easton Md</u>							

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death.**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAY 5 1914  
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Baltimore</u>		4223		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Neer Trappe</u> (No. _____) St.; _____ Ward) _____		Registered No. <u>295</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Alice Parrott</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>April 17<sup>th</sup>, 1914</u> (Month) (Day) (Year)					
7 AGE <u>Still born</u> If LESS than 1 day, ____ hrs. ____ min. ? ____ yrs. ____ mos. ____ ds.					
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>Franklin M. Parrott</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
	12 MAIDEN NAME OF MOTHER <u>Naomie Ravens</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Franklin M. Parrott</u> (Address) <u>Trappe</u>					
15 Filed <u>Apr. 17<sup>th</sup>, 1914</u> <u>Joseph G. Coon, M.D.</u> LOCAL REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>April 17<sup>th</sup>, 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____ to _____, 191____ that I last saw him _____ alive on <u>(Still birth)</u> , 191____ and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>hemorrhage from premature separation of the placenta</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>William S. Seymour</u> , M. D. <u>Apr. 17<sup>th</sup>, 1914</u> (Address) <u>Trappe, Md.</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Private grave yard in</u>				DATE OF BURIAL <u>Apr. 18<sup>th</sup>, 1914</u>	
20 UNDERTAKER <u>(none) Premieris</u>				ADDRESS _____	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

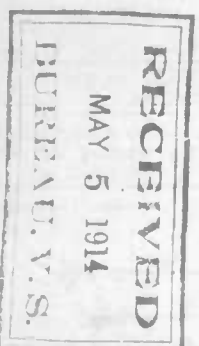
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *23 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **4224**  
County **Talbot**

Village or City **Lewistown** (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. **290**

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME **John E Primrose**

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **male** 4 COLOR OR RACE **Colored** 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED **married**  
(Write the word)

6 DATE OF BIRTH **unknown**, 1874  
(Month) (Day) (Year)

7 AGE **40** yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. 11 LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ mo. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work **Farm hand**  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) **Maryland**

10 NAME OF FATHER **John Primrose**

11 BIRTHPLACE OF FATHER (State or country) **Maryland**

12 MAIDEN NAME OF MOTHER **Maggie Rabin**

13 BIRTHPLACE OF MOTHER (State or country) **Maryland**

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Harriet Primrose (X)**

(Address) \_\_\_\_\_

15 Filed **April 7, 1917** **J. B. Fairbank** REGISTRAR  
**Local**

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **April 8, 1917**  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **April 4, 1917** to **April 8, 1917**, that I last saw him alive on **April 4, 1917**

and that death occurred on the date stated above, at **1 P. M.**  
The CAUSE OF DEATH\* was as follows:

**Valvular Disease of heart**

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) **W. W. Balmer** M. D.  
1917 (Address) **Easton, Md.**

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL **Old Chapel** DATE OF BURIAL **4/10, 1917**

20 UNDERTAKER **Frankton Orman & Son** ADDRESS **Easton Md**

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAY 5 1914  
BUREAU, V. S.



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N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Balbot</u>		4225	91		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>near Grappe</u>		(No. _____, St.; _____ Ward)			Registration Dist. No. <u>292</u>	
2 FULL NAME <u>Joseph. Bond. Purnell.</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Negro.</u>	5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) <u>Single</u>				
6 DATE OF BIRTH <u>February 19th, 1914</u> (Month) (Day) (Year)						
7 AGE yrs. <u>1</u> mos. <u>24</u> ds.		If LESS than 1 day, _____ hrs. OR _____ min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer)						
9 BIRTHPLACE (State or country) <u>Balbot Co, ind -</u>						
PARENTS	10 NAME OF FATHER <u>William Green.</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>Balbot Co ind -</u>					
	12 MAIDEN NAME OF MOTHER <u>Sarah Gertrude Purnell</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Balbot Co, ind</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>William Purnell JAR,</u> (Address) <u>Grappe, ind -</u>						
15 Filed <u>Apr. 13th</u> , 191 <u>4</u> <u>Joseph A Bond ind</u> REGISTRAR						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>April 13th</u> , 191 <u>4</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred on the date stated above, at <u>4 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Bronch. Pneumonia</u> (Duration) _____ yrs. _____ mos. <u>3</u> ds. Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>Joseph A Bond</u> , M. D. <u>Apr. 13th</u> , 191 <u>4</u> (Address) <u>Grappe ind</u> State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>near Grappe, ind.</u>					DATE OF BURIAL <u>April 13th</u> , 191 <u>4</u>	
20 UNDERTAKER <u>William Purnell.</u>					ADDRESS <u>Grappe ind.</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

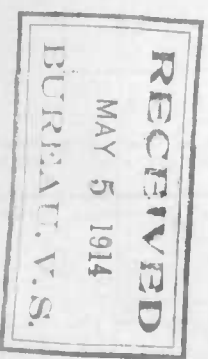
Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4226  
County Talbot

Village or City Easton Md. (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

2 FULL NAME Stella Brown

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 190

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH April 17, 1914  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Talbot Co

10 NAME OF FATHER George Raison

11 BIRTHPLACE OF FATHER (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Carrie Thomas

13 BIRTHPLACE OF MOTHER (State or country) Talbot Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maria Thomas

(Address) Easton Md.

15 Filed 4/18, 1914 J. B. Fairbank  
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 17, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr. 17, 1914, to Apr. 17, 1914.

that I last saw him alive on \_\_\_\_\_, 191\_\_\_\_\_

and that death occurred on the date stated above, at 11:30 a. m.  
The CAUSE OF DEATH\* was as follows:

Stella Brown

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory \_\_\_\_\_  
Secondary \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) James B. Thomas 3d, M. D.  
Apr. 17, 1914 (Address) Easton Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St. Ann's Church DATE OF BURIAL 4/18, 1914

20 UNDERTAKER James A. Spencer ADDRESS Easton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAY 5 1914

BUREAU, V. S.

4227

## 1 PLACE OF DEATH

County SalbotSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 291Village or City St. Michaels (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

James Rick

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)6 DATE OF BIRTH April 2nd, 1914 (Month) (Day) (Year)7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work \_\_\_\_\_ (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) St. Michaels Md.10 NAME OF FATHER Jarvis Rick11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Crisella Smith13 BIRTHPLACE OF MOTHER (State or country) Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant Annie Smith (Address) St. Michaels Md.15 Filed April 7th, 1914 John Horwath Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 6th, 1914 (Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from April 2nd, 1914, to April 6th, 1914, that I last saw him alive on April 6th, 1914and that death occurred on the date stated above, at 1 P. m. The CAUSE OF DEATH\* was as follows:Cyanosis(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.

Contributory (Secondary) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) E. Michan, M. D. April 6th, 1914 (Address) St. Michaels

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, it not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St. Michaels Cemetery DATE OF BURIAL April 7th, 191420 UNDERTAKER The Father ADDRESS St. Michaels Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

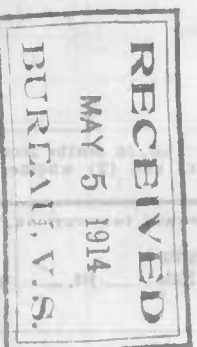
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*, *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths—state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4228  
County Talbot Co

Village or City Easton

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 290

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James Hoffman Richardson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH Nov 28, 1896  
(Month) (Day) (Year)

7 AGE 17 yrs. 4 mos. 29 ds. It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Porter  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Penn

PARENTS  
10 NAME OF FATHER Saml E Richardson  
11 BIRTHPLACE OF FATHER (State or country) Penn  
12 MAIDEN NAME OF MOTHER Florence Jones  
13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Elmer A. Richards  
(Address) 217 Hanson

15 Filed Apr 27, 1914 J. B. Fairbank  
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 27, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 27, 1914, to Apr 29, 1914, that I last saw him alive on Apr 20, 1914

and that death occurred on the date stated above, at 9:40 a.m.  
The CAUSE OF DEATH\* was as follows: Pithe disease

(Duration) yrs. 6 mos. ds.  
Contributory Quarantine (Secondary)

(Duration) yrs. 6 mos. ds.  
(Signed) P. L. Traver, M. D.  
Apr 27, 1914 (Address) Easton Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted, If not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Phila Pa DATE OF BURIAL 4/29, 1914

20 UNDERTAKER Frankton Oman & Son ADDRESS Easton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Typhoid," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAY 5 1914

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4229  
 County Talbot  
 Village or City Tilghman (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)  
 2 FULL NAME John Shendollar  
 Registration Dist. No. 294  
 [It death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Aug. 17, 1832  
 (Month) (Day) (Year)

7 AGE 81 yrs. 7 mos. 13 ds. 1 LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work Carpenter  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany

PARENTS  
 10 NAME OF FATHER Not Known by children  
 11 BIRTHPLACE OF FATHER (State or country) Not Known  
 12 MAIDEN NAME OF MOTHER Not Known  
 13 BIRTHPLACE OF MOTHER (State or country) Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

X (Informant) Mary E. Stitches

X (Address) Baltimore

15 Filed Apr. 7th, 1914 W. J. Jackson  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 4, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1914, to April 4, 1914, that I last saw him alive on April 4, 1914

and that death occurred on the date stated above, at 2 P. m.  
 The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia  
 (Duration) — yrs. — mos. 6 ds.

Contributory Secondary

(Signed) S. Kennedy Wilson, M. D.  
Apr. 5th, 1914 (Address) Tilghman

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, it not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Tilghman April 7, 1914

20 UNDERTAKER ADDRESS

E. P. Sparks St. Michael

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

2725 Penn av -

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

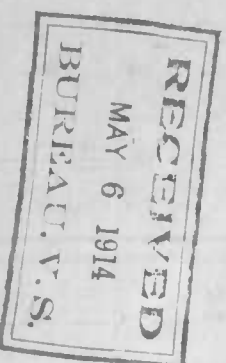
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4230

County

Talbot

Village or City

Chabonne, Md.

(No.)

St.; Ward)

Registration Dist. No. 294

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Thomas James Sinclair

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widower

6 DATE OF BIRTH Jan. 8th, 1842  
(Month) (Day) (Year)

7 AGE 72 yrs. 3 mos. 7 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Waterman  
(b) General nature of industry, business, or establishment in which employed (or employer) Cysterman

9 BIRTHPLACE (State or country) Talbot Md.

10 NAME OF FATHER James Sinclair

11 BIRTHPLACE OF FATHER (State or country) Talbot Co. Md.

12 MAIDEN NAME OF MOTHER Jane E. Gibson

13 BIRTHPLACE OF MOTHER (State or country) Talbot Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John B. Sinclair

(Address) Talbot Co. Md.

15

Filed

April 17, 1914

Wm S. Lowe Deputy Local REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 15, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1913, to April 15, 1914.

that I last saw him alive on April 14, 1914.

and that death occurred on the date stated above, at 5 a. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Rectum  
(Duration) 1 yrs. 1 mos. ds.

Contributory General Cachexia

(Signed) Louis H. Seth, M. D.  
4/17, 1914 (Address) 22 Daniel Rd.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shemond

April 17, 1914

20 UNDERTAKER

ADDRESS

E P Sparks

H Michaels

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

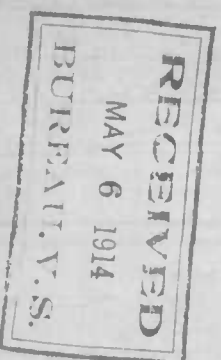
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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**1 PLACE OF DEATH** 4231  
 County Baltimore  
**STATE OF MARYLAND**  
**CERTIFICATE OF DEATH**  
 Registration Dist. No. 291  
 Village or City Bellevue (No. \_\_\_\_\_) St.; \_\_\_\_\_ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]  
**2 FULL NAME** Charles L. Smith

**PERSONAL AND STATISTICAL PARTICULARS**

**3 SEX** Male **4 COLOR OR RACE** Colored **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** Single (Write the word)

**6 DATE OF BIRTH** don't know, 1897 (Month) (Day) (Year)

**7 AGE** 17 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

**8 OCCUPATION**  
 (a) Trade, profession, or particular kind of work Labourer  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

**9 BIRTHPLACE** (State or country) Maryland

**PARENTS**

**10 NAME OF FATHER** Geo Smith

**11 BIRTHPLACE OF FATHER** (State or country) Maryland

**12 MAIDEN NAME OF MOTHER** Fanny Thomas

**13 BIRTHPLACE OF MOTHER** (State or country) Maryland

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
 (Informant) Charlotta Adams  
 (Address) Bellevue Md.

**15**  
 Filed May 14, 1914 Mary M. Denny  
Deputy REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH** April 30, 1914 (Month) (Day) (Year)

**17 I HEREBY CERTIFY**, That I attended deceased from March 13, 1914, to April 30, 1914, that I last saw him alive on April 29, 1914, and that death occurred on the date stated above, at 11 a.m.  
 The CAUSE OF DEATH\* was as follows:  
Pneumonia  
 (Duration) about 6 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Contributory Exhaustion  
 Secondary (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 7 ds.  
 (Signed) S. D. Willson, M. D.  
May 6, 1914 (Address) Shirley's 2nd  
 \*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE** (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
 At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Where was disease contracted, If not at place of death?  
 Former or usual residence \_\_\_\_\_

**19 PLACE OF BURIAL OR REMOVAL** Bellevue **DATE OF BURIAL** May 14, 1914

**20 UNDERTAKER** L. Scott Halmon **ADDRESS** Royal Oak

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

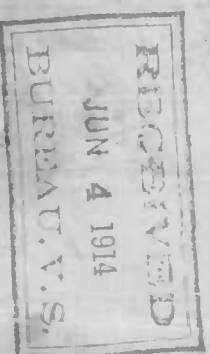
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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## 1 PLACE OF DEATH

4232

County

Baltimore

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

292

Village or City

Neasopolis

(No.

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Bernard Snyder

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

Sept 1

(Month)

(Day)

(Year)

If LESS than 1 day, hrs.

OR min. ?

7 AGE

47 yrs.

7 mos.

21 ds.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Waterman

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Germany

## PARENTS

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Mazie Taylor

(Address)

Offspring Md

15

Filed

April 22, 1914

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 21

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on

Mar 30

1913

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Resolved wound through head suicidal after suffering with carcinoma of stomach (Duration) 1 yrs. 0 mos. 0 ds.

Contributory

Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

J. M. E. C. M. D.  
Acting Coroner  
191 (Address) Office Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Offspring Cemetery

April 22, 1914

20 UNDERTAKER

ADDRESS

M. E. Newman &amp; Co. Offspring Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

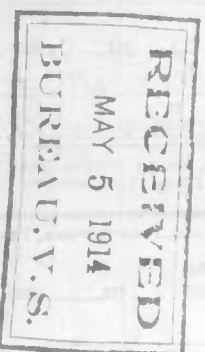
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4233

County TalbotVillage or City Easton (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

(64) STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 190

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

2 FULL NAME Ellen Stanford

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH Unknown, 1830  
(Month) (Day) (Year)

7 AGE 84 yrs. — mos. — ds. It LESS than 1 day, .... hrs. OR .... min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work at home  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Caroline Co

10 NAME OF FATHER Gabriel Friend

11 BIRTHPLACE OF FATHER (State or country) Caroline Co

12 MAIDEN NAME OF MOTHER Grace Chase

13 BIRTHPLACE OF MOTHER (State or country) Caroline Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Holmes(Address) Easton Md

15 Filed 4/20, 1914 B. Fairbank  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 19, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1914, to April 18, 1914,  
that I last saw her alive on or about April 14, 1914

and that death occurred on the date stated above, at 12.30 m.  
The CAUSE OF DEATH\* was as follows:

Apoplexy

(Duration) .... yrs. .... mos. .... ds.

Contributory  
Secondary

(Duration) .... yrs. .... mos. .... ds.

(Signed) W. W. Palmer, M. D.  
, 1914 (Address) Easton Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL Trinity Pleasant Co Church  
Caroline Co DATE OF BURIAL 4/21, 1914

20 UNDERTAKER James A. Spruice ADDRESS Easton Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

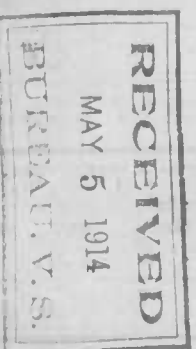
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4234

County

Fallot

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

290

Village or City

Easton Md. Emergency Hospital

Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Jm N. Thomas

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Cobalt

5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Unknown, 1868

7 AGE

46 yrs. — mos. — ds. OR LESS than 1 day, — hrs. — min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Saw Mill

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Nicholas Thomas

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

11

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. R. Bitchett

(Address)

Greensboro Md

15

Filed

4/17, 1914 J. B. Fairbank

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 5, 1914

17

I HEREBY CERTIFY, That I attended deceased from

Apr 2nd, 1914 to Apr 5th, 1914

that I last saw him alive on Apr 4th, 1914

and that death occurred on the date stated above, at 7 a. m.

The CAUSE OF DEATH\* was as follows:

Blow from a timber sweep on the back 2 hrs. week fracturing 5th cervical vertebra and crushing spinal cord completely

(Duration) yrs. mos. ds.

Contributory  
Secondary

Shock and paralysis

(Duration) yrs. mos. ds.

(Signed)

P. L. Bowers

M. D.

Apr 6th, 1914 (Address) Easton, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greensboro Md

4/7, 1914

20 UNDERTAKER

ADDRESS

Mrs A. Spence Easton Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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RECEIVED

MAY 5 1914

BUREAU U. V. S.



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1 PLACE OF DEATH **4235**  
County Talbot.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 290

Village or City Queen Anne (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Larinda Willis

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 MARRIED, Married  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH Jan 18, 1847  
(Month) (Day) (Year)

7 AGE 67 yrs. 2 mos. 18 ds. IF LESS than  
1 day, \_\_\_\_\_ hrs.  
OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) New Castle Co. Del.

10 NAME OF FATHER Joseph H. Turner

11 BIRTHPLACE OF FATHER (State or country) Delaware

12 MAIDEN NAME OF MOTHER Sarah Hellaplaine

13 BIRTHPLACE OF MOTHER (State or country) Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank M. Willis

(Address) Queen Anne Md.

15 Filed 4/8, 1914 J. B. Fairbank  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 5, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April, 1914, to Apr 5, 1914,

that I last saw her alive on April 5, 1914,

and that death occurred on the date stated above, at 4 P. M.,

The CAUSE OF DEATH\* was as follows:

Pneumonia

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory (Secondary) Tuberculosis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Howard R. Hopkins, M. D.  
Apr 7, 1914 (Address) Hallebrook Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Easton Md

4/8, 1914

20 UNDERTAKER

ADDRESS

James A. Spence Easton Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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BUREAU, V. S.